DENTAL EXAMINATION RECORD

INFORMATION ON THIS FORM MAY BE SHARED WITH APPROPRIATE PERSONNEL FOR HEALTH AND EDUCATIONAL PURPOSES.

TO BE COMPLETED BY THE PARENT: *(THIS PORTION ONLY)*

PUPIL'S NAME: LAST FIRST MIDDLE	BIRTH DATE MONTH DAY YEAR
ADDRESS: STREET CITY ZIP CODE	TELEPHONE:

NAME OF SCHOOL:	GRADE LEVEL	SEX: ☐ MALE ☐ FEMALE

PARENT OR GUARDIAN:	ADDRESS:

1. IS YOUR CHILD RECEIVING FLUORIDE TREATMENTS IN SCHOOL? ☐ YES ☐ NO COMMENT ______________________

2. DOES YOUR CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE DENTAL TREATMENT? (i.e., ALLERGIES, DIABETES, RESPIRATORY DIFFICULTY, HISTORY OF RHEUMATIC FEVER, ETC.) ☐ YES ☐ NO EXPLAIN ______________________

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

☐ URGENT – (ABSCESS FORMATION, NERVE EXPOSURE, ADVANCED DISEASE STATE INCLUDING HANDICAPPED INDIVIDUALS)

☐ ROUTINE DENTAL CARE NEEDED – (ALLOYS, COMPOSITES, STAINLESS STEEL CROWNS, ETC.)

☐ PREVENTIVE DENTISTRY ONLY NEEDED – (PROPHYLAXIS, FLUORIDE TREATMENT, SEALANTS, ETC.)

☐ NO TREATMENT REQUIRED

☐ OTHER ______________________

PATHOLOGY PRESENT

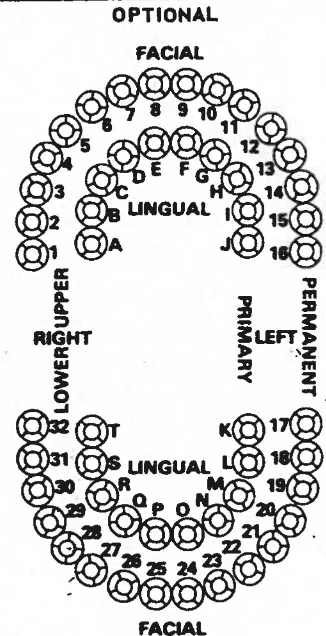
HARD TISSUE ☐ YES ☐ NO DESCRIBE ______________________

SOFT TISSUE ☐ YES ☐ NO DESCRIBE ______________________

MALOCCLUSION ☐ YES ☐ NO TYPE ______________________

ORTHODONTIC REFERRAL RECOMMENDED ☐ YES ☐ NO

OPTIONAL



OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY / LOCATION
BLOCK IN FILLINGS PRESENT

SIGNATURE OF DENTIST: ______________________ DATE: __________

TELEPHONE:

ADDRESS: ______________________
STREET CITY ZIP CODE

PLEASE PRINT OR STAMP

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